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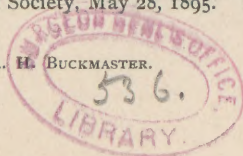
Two years ago, in a paper read before this Society, I used the following language: "I fully believe, if it were the rule in every case of fibroid of the uterus to make hysterectomy before the patient was exhausted by hæmorrhages, peritonitis, salpingitis, and consequent invalidism—in short, if we operated upon all cases in the early stages, as we all advise for cystoma of the ovary—that our mortality would be no more, and at the end of a year we would have a much greater sum of human happiness and relief to physical suffering."

This and other papers on the same subject gave rise to one of the most animated, exciting, and interesting discussions in the whole history of the Society. My friend, Dr. Mundé, severely criticised my position, and declared that in his own experience and practice only about "ten per cent. of the cases he had seen required treatment" (presumably surgical treatment). Farther on in the discussion he says, "In my opinion at least seventy-five per cent. of these do not require an operation, or, indeed, any surgical treatment."

Fortunately for the credit of the profession, as I believe, the large majority of those who took part in the discussion did not indorse Dr. Mundé's views, while many, and notably those of large experience, more nearly approved the position I assumed in my paper.

The general sentiment was in favor of removing all uteri contain-

* Read before the American Gynæcological Society, May 28, 1895.



ing fibroids that had given the woman sufficient trouble to cause her to seek relief. The great point of difference was as to what would really be the degree of suffering to justify surgical interference.

Believing now, after two years of much larger experience, that any discovered fibroid may soon or late become a source of trouble and the foundation for invalidism, I honestly and conscientiously adhere to the position then taken. I have steadily and uniformly followed the practice of the principle then laid down, and have seen no reason to regret it. In every case where I had the consent of the patient I have made hysterectomy, and in a large majority of the cases complete hysterectomy, as advocated in a paper read before the American Medical Association in 1892, entitled *Hysterectomy without Pedicle*. The more I make this last operation (complete hysterectomy) the better satisfied I am with results. I rarely have unpleasant complications arising after. In several very recent cases, where I have removed the entire cervix, there has been an uneventful recovery, with scarcely a rise of temperature. However little of the cervix is left, there will always be more or less danger from septic material in the cervical canal, and although one may cauterize by the very best methods, pus may result. Again, I do not close the vaginal opening so completely as to prevent serous drainage between the sutures; and inasmuch as I rarely use drainage in any other form, I am sure that this proves sufficient. In all cases the utmost care is taken before operation to render the vagina as aseptic as possible. I also instruct nurses to use a douche (1 to 5,000 bichloride) every day so long as a discharge continues. Within a year past I have had no death from hysterectomy made for fibroid of the uterus—about twenty operations in all; nearly half have been complete, the others some portion of the cervix has been left. The difference in rise of temperature, pain, and other complications has been very strikingly in favor of complete extirpation. The principal objections, heretofore, have been the increased length of time required to perform the operation, but my own experience confirms me in the belief that but little more time is required now than was formerly demanded in the partial removal. Having the complete removal in view at the commencement, one can save much time that was formerly spent in minor details of a different operation.

The difficulties of any hysterectomy come largely from complications that have arisen from delay, and this is especially true in making the complete removal. No uterus can long remain normal that contains a fibroid. Septic material may and frequently does extend into the Fallopian tubes, thence into the pelvic cavity, where peri

tonitis results in suppuration, exudate, and adhesions that bind down the cervix, so that it becomes almost impossible to enucleate or dissect it out. This I have found a frequent complication. Fibroids become multiple, occupying all parts of the uterus, and extending into and changing the position of the broad ligaments, displacing the ureters, and fixing portions of the intestines by contact with the congested peritonæum. The whole circulation is modified and becomes pathological, the veins of the broad ligament are varicose, the tissues become friable, increasing the danger from hæmorrhage during the process of removal. To my mind, the chief danger in long operations lies in the amount of blood lost, rather than any shock to the system otherwise. "Death from shock," when analyzed, as a rule, means death from hæmorrhage. I speak from my own experience and observation of other operators. It is not a mere theory I have formed, but comes, as all theories in practical surgery should come, from practical work

It is often said, especially by men who take what they term the "conservative" side of treatment of fibroids, that in a majority of cases the patient goes through life and is not rendered an invalid by the growth, but enjoys a degree of health and comfort that the average woman enjoys. Most careful and searching inquiry, on my part, among such women shows the reverse of this to be true. First of all the knowledge of such an unnatural growth is a constant source of anxiety and worry of mind, which is worse than physical suffering. The dread of some complication is always before them, to say nothing of the disagreeable deformity that they cause after they are large enough to rise above the pubes. In the case of an unmarried woman this last-named feature becomes exceedingly annoying. Add to this the well-marked invalids that barely exist, unable to take life's burdens and cares or even be free from daily suffering, we have a factor that weighs much against the slight risk of hysterectomy.

Homans, in an article published in the *Boston Medical and Surgical Journal*, March 7th, ult., speaks more strongly than ever before in favor of the operation. He gives eleven reasons why he advises operation, while practically he gives but one reason for not operating—viz., when the tumor gives no trouble, uneasiness, or disturbance, and the patient does not desire the removal. The last part of this reason always settles the matter, while the first part, in my experience, is extremely rare. He adds, "but I operate more frequently than I used to." Out of six hundred and fifty fibroids he had seen he operated upon ninety-three; but says: "I should have done well to have operated upon a

greater proportion of them. He estimates that the "mortality from all cases, promising and unpromising, varies from three to ten per cent."

Following the rule I have laid down, "to operate on all cases as early as discovered" and by "*complete hysterectomy*," in my opinion, the mortality will be no more than the minimum—three per cent. Can we ask more than this for abdominal section for any cause?

Left until an absolute necessity compels the operation (as claimed by our "conservative" (?) friends), we will find a mortality far exceeding the maximum, to say nothing of the dangers from death by hæmorrhage and peritonitis, and the years of physical and mental suffering. There will always be a certain percentage of cases that will undergo malignant and other degenerations and complications that will render impossible any attempt even at removal.

The size of a tumor is by no means the measure of the suffering it may occasion, the largest oftentimes being less troublesome than small ones. I have within a few weeks removed a uterus containing two fibroids no larger than acorns. They had caused hyperplasia of the corpus and a complete and very sharp retroflexion. The woman had been an invalid for years and I proposed ventro-fixation to relieve the displacement, to which she assented. Exploratory incision showed the true condition and I made hysterectomy. I have no doubt of its complete success so far as restoring her to health and comfort. Another case, a week later, showed three very small tumors, so placed in the pelvis as to render an operation very difficult and dangerous. Pressure upon the uterus had produced much atrophy of the organ, the function had become considerably impaired, and the lady had been an invalid to the extent of depriving her of all social privileges and enjoyment for many years. Yet the largest of these fibroids was no more than two inches in diameter. Rapid and uneventful recovery followed. I have no doubt as to complete recovery of health in this case. These are only samples of many such cases that occur under the eyes of frequent operators.

As this paper is merely a brief summing up of my own experience, I forbear quoting at any length from any authorities. The journals are full of articles bearing upon the subject. Homans says, "I doubt if one man could read in a day the communications published during twenty-four hours on this operation." All this shows the manifest interest in the subject. The profession seems fully awake to it, and hasten to put themselves on record in favor, rather than against surgical interference. Judging from all these indications, one must

be led to believe that hysterectomy for uterine fibroids, as a rule, has come to stay, and that a much greater percentage than "ten" will be removed in this way, whether it is best or not. If the "education" in this direction does not result in tempting men who have not had experience in abdominal surgery for other causes, many a suffering woman will be relieved.

That the operation is much more difficult than abdominal cases generally, I think will be readily granted by men of large experience. Especially is this true in cases of long standing, where adhesions and complications exist—then indeed it becomes actual manual labor. Almost every man has his own method of operating. I have never changed mine since I adopted the *continuous suture with catgut* about twelve years ago. So far as I know, no one who has written on the technique of the operation has ever adopted this method. Most men seem afraid of the catgut suture. Since 1884 I have used no silk, silver wire or any form of suture or ligature aside from catgut in the abdominal cavity or out of it, with the single exception of silk-worm gut for closing abdominal wounds. I have never regretted its use, and have had, in my opinion, no unpleasant results, which would not have occurred with any other form of suture or ligature. With well-prepared catgut I feel the utmost safety both as regards aseptics and freedom from hæmorrhages after operation. It has a special advantage over many forms of ligature, in that you can use it freely by continuous suture where the same amount of silk would be a great objection. In this special operation after placing a long clamp beneath the ovary and tubes, with a strong curved needle threaded with No. 4 or 5 catgut, I ligate a portion of the broad ligament an inch below the clamp, carefully fastening by over-and-over sewing this part. I then cut between the clamp and ligature, and as fast as I cut continue the over-and-over suture, always keeping one loop ahead of the knife or scissors. In this way I close the broad ligament as soon as cut. When I have divided the broad ligament down as far as the uterine artery, and before cutting it, I carry an incision around the uterus in line with the last suture, through the peritonæum which I dissect off both in front and behind, continuing the suture as before—this includes the uterine artery, and no blood is lost in the average case, where the tissues are not impaired in their integrity. A little care and patience soon relieves the cervix, and by that time the continuous suture has nearly closed the vaginal opening, so far as I care to do so.

As I said in a former paper, I have tried the various other meth-

ods for hysterectomy, but at last settled on this, which I find much easier than any other I know at present.

The advantages I claim for it are: 1. In my hands it is easier to do than any other method. 2. By using catgut one has less fear of strangulating the tissues on account of its elasticity. 3. By the continuous suture one can always have the blood-vessels under control by carrying a loop of the suture below the point of division, before cutting the vessel. 4. If tissues are weak and fragile from inflammatory action, the catgut suture can be used in any direction to almost any extent, in the event of annoying bleeding. 5. Absorption of catgut always takes place, so that there is much less danger from fistulæ following, which so often occur when silk is left in the pelvic and abdominal cavity. 6. In my experience, no casualties have followed its use that may not have followed any kind of suture.

Many operators can possibly remove the uterus more rapidly by their own methods, but the time necessary to secure all bleeding vessels and completing the toilet will make the entire operation as long as mine. When I take my last suture the vessels are all secure and the rest is rapidly finished. I have seen the uterus removed in ten minutes, but from half an hour to an hour was spent in getting the patient ready for bed. This I call "playing to the galleries," and is not scientific surgery. I find very little trouble from prolonged operations, provided hæmorrhage is avoided and prevented; with plenty of gauze and hot towels the intestines can be kept warm, and no shock follows from even hours of exposure.

In conclusion, I can only say, that further experience and careful observation justifies me in reasserting my belief, so strongly expressed two years ago, that in all cases where a woman finds herself an invalid from a fibroid uterus to the extent of seeking the advice of a surgeon, unless such tumor can safely and easily be removed *per vaginam*, either by enucleation or morcelllement, true conservative surgery demands hysterectomy, and, in my experience, I have found the abdominal method by far the preferable one.

I expect criticism upon my method of operating by continuous suture with *catgut* as the material. I think I may safely say that it is entirely original with me, and therefore I am perfectly willing to submit to whatever discredit attaches to the method. It has served me well for ten years, at least, and several of my friends in the profession are abundantly satisfied with it.

